

June 19, 2007

REVISED

Los Angeles County Board of Supervisors

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To improve health through leadership, service and education.

TO:

Each Supervisor

FROM:

Bruce A. Chernof, M.D.

Director and Chief Medical Office

SUBJECT:

CORRECTIVE ACTION PLAN FOR IMMEDIATE

JEOPARDY

This is to provide you with a copy of the Plan of Correction submitted last night, as required, to the Centers for Medicare and Medicaid Services (CMS) to address CMS' findings of an immediate jeopardy situation during their survey in the Emergency Department at Martin Luther King Jr. — Harbor Hospital (MLK-H) on June 7, 2007 and reported to the hospital on June 12, 2007.

The basis for the immediate jeopardy finding focused on three main areas that CMS identified:

The first finding involved a patient who required transfer for a neurosurgical condition (neurosurgery is a specialty not available at MLK-H). We have established a transfer process for neurosurgical patients that calls for immediate transfer of patients with specific neurosurgical diagnoses to our other hospitals on a rotating basis. We have also established a monitoring plan to ensure that these transfers occur expeditiously.

The second finding was the performance of medical screening exams by physician's assistants. Although physician's assistants may perform medical screening exams as part of their scope of practice, they must be specifically credentialed for this. CMS' concluded that the credentialing process had not been completed as required under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). As a result of this finding, on June 12, 2007 MLK-H leadership directed California Emergency Physicians (CEP), the emergency department contract group, to immediately discontinue the use of physician's assistants for medical screening exams. These exams will now be performed only by the Emergency Department attending physicians. Additionally, MLK-H has discontinued the use of non-emergency physician's assistants as consultants in the Emergency Department.



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Each Supervisor June 19, 2007 Page 2

The third finding related to the timing of the medical screening exam. CMS found that there were delays in completing medical screening exams for patients presenting to the Emergency Department. To address this deficiency, the leadership in the Emergency Department, Nursing, and Hospital Administration redesigned the process by which patients are seen in the Emergency Department. That redesign includes co-locating nursing and registration staff in the triaging area (the initial point of contact with the patient) with physicians available so that an immediate medical screening can be completed. Further, training was provided to emergency room nurses to ensure that physicians are contacted if management is needed prior to the medical screening exam.

Another important finding was that there were repetitive delays in care related to coordination of services. In each instance, appropriate multidisciplinary interventions have been developed, and implemented with appropriate monitoring put in place. The hospital had previously added an additional hospitalist physician (inpatient doctor) to improve patient care and patient transfers.

These findings are not acceptable and are discouraging in the face of the enormous effort to reform the hospital. They are grave and must be cured or the facility cannot continue to operate. Each citation has a definitive corrective action with close monitoring. We believe that these corrective actions fully address CMS' concerns and that CMS will release the immediate jeopardy finding. We expect CMS to return to the hospital to validate these corrective actions within the next week.

If you have any questions or need additional information, please let me know.

BAC:jrc

Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors



Los Angeles County **Board of Supervisors**

June 18, 2007

Gloria Molina First District

Yvonne B. Burke Second District

Zev Yaroslavsky Third District

> Don Knabe Fourth District

Michael D. Antonovich Fifth District Steven D. Chickering

Western Consortium Survey and Certification Officer

Centers for Medicare and Medicaid Services

Division of Survey and Certification 90 7th Street Suite 5-300(5W) San Francisco, CA 94103-6707

Dear Mr. Chickering:

IMMEDIATE JEOPARDY NOTICE: CCN 05-0578 - MARTIN LUTHER KING, JR. HARBOR HOSPITAL

Attached for your consideration is the Plan of Correction prepared by Martin Luther King.

Jr.-Harbor Hospital ("MLK-Harbor") in response to the Centers for Medicare and Medicaid

Services' ("CMS") notice of intent to terminate the hospital's participation in the Medicare

program because of immediate jeopardy to patient health and safety. Also attached are

the various documents which are referenced in that Plan of Correction. Together these

materials credibly demonstrate that the actions necessary to correct the immediate jeopardy to patient health and safety have been taken, such that CMS may remove its finding, and return to the terms of the Extension Agreement between the parties.

Via Facsimile and United States Mail

Antionette Smith Epps Administrator

> Roger A. Peeks, MD Circl Medical Officer

Dellone Pascascio, RN Chief Nursing Officer

> We have included in the beginning of the Plan of Correction a discussion of the five immediate correction actions outlined in Paragraph 1 of your June 12, 2007, letter, as well as the corrective action requested in Paragraph 2(a). The corrective actions discussed in the remainder of Paragraph 2 were incorporated into the responses to individual findings on the form 2567. More particularly, those responses include:

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> Tel: (310) 568-5201 Fax: (310) 638-8193

- Ceasing the use of Physician Assistants to provide medical screening examinations so that only licensed and credentialed physicians will perform those examinations (Paragraph 2(b)).
- Redesigning the triage/intake process so that the provision of medical screening examinations is assured (Paragraph 2(c)).
- Training its emergency room nurses to contact a physician whenever a patient awaiting care in the emergency room waiting area requires an Intervention for pain and not to wait for the screening examination.
- Implementing a new protocol to expedite the transfer of neurosurgical patients, and instituting a "no refusal" policy which requires sister county hospitals to accept such patients promptly. In addition, a mechanism was created to assure that high level clinical contacts are made whenever difficulty is encountered in transferring patients of any kind (Paragraph 2(e).

To provide compassionate, high quality care that improves the health status of our patients, their families and the communities we serve without regard to ability to pay



Steven D. Chickering June 18, 2007 Page 2

- Assigning a hospitalist to the emergency room to manage individuals who have internal medicine or certain other issues and are awaiting transfer or admission (Paragraph 2(d)). The assignment of a dedicated hospitalist, who will be in the emergency department 24/7, will assure that those patients receive the level of physician attention that they would if they were admitted, and also will help remove impediments to patient transfers. To assure the proper stabilization and treatment for patients who will continue to be managed by the emergency physicians, the emergency physicians have received reinforcing education on documentation, and continuing assessment responsibilities. A requirement for the physician to assess each patient at the beginning of each shift has been added and compliance is being monitored.
- Developing a monitoring plan for every corrective action, aside from individual counseling, generally involving daily or weekly chart review, and remediating deficiencies immediately if they continue. Moreover, the data from such monitoring is provided to the Performance Improvement Committee for its use and integration into MLK-Harbor's quality improvement program (Paragraph 2(g) and (h).)

No corrective actions have been implemented with respect to Patient P, as we believe that survey findings do not accurately reflect the actual care received by this individual. For example, those findings do not reflect that the patient received a medical screening examination within less than 2 hours of presenting to the emergency room, and that after receiving some diagnostic tests, including an ultrasound, she was seen by a specialist at 1600 hours. That specialist determined that the proper course of treatment was simply observation of the patient, which occurred while the patient was awaiting inpatient placement. That placement took place at 2000, not at 2100 as noted by the surveyor. Thus, the patient did timely receive the medical care appropriate to her clinical situation, and no corrective actions were necessary.

We note that, as of June 17, 2007, MLK-Harbor had not been provided with a key to identify the specific patients for whom there were findings. While it believes that it is has determined who most of the patients are, it reserves the right to develop and present additional corrective actions after CMS has disclosed the identity of those patients.

Notwithstanding that reservation, MLK-Harbor believes that significant, appropriate corrective actions have and will continue to be made which assure the safety and timely treatment of patients who present to its emergency department. Accordingly, we urge CMS to authorize a resurvey and to revoke its decision to terminate the hospital on June 30, 2007.

If you have any questions regarding the attached materials, please do not hesitate to contact me.

Sincerely.

Antionette Smith Epps

Administrator

ASE:rs

Attachments

c: Michelle Griffin Jackie Lincer

Bruce A. Chernof, MD

PRINTED: 06/12/2007 FORM APPROVED OMB NO. 0938-0391

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	• •				Medicare and Medicaid services (CMS) following actions were taken:	, the	
	The following reflec	ts the findings of the			REASSIGNMENT OF PHYSICIAN		
	Department of Heal				ASSISTANTS	lha ED	6/19/07
	investigation of EM	TALA complaint # 117102.			 The Chief Medical Officer notified Medical Director that physician as: 		0/13/0/
		· · · · · · · · · · · · · · · · · · ·			shall no longer perform medical so	reening	
		epartment of Health Services:			examination. (Attachment A) The I Medical Director informed each ph	:D vsician	ĺ
	Supervisor	Health Facilties Evaluator			assistant by e-mail that they may r	o longer	
		M.D., Medical Consultant			perform individual medical screeni examination.	ng	
		., Health Facilities Evaluator			COMPETENCY TO PERFORM MEDIC	AL	
	Nurse	·			b. See attached. (Attachment B)		
A 455		RATION OF EMERGENCY			NUMBER AND QUALIFICATIONS OF	STAFF]
	SERVICES				ASSIGNED c. Attached is a schedule of the number of the n		
	The consider must be	oe integrated with other			persons assigned to the emergence		
	departments of the				urgent care services, broken down		
		inoopitatii			classification and qualifications. (Attachment C)		
	This STANDARD is	not met as evidenced by:			NUMBER AND QUALIFICATIONS OF NEEDED	STAFF	;
		on, interview and record			d. Attached is a schedule of the num	per of full	
		falled to ensure the timely			time equivalents (FTE), needed in		
	provision of emerge	ncy services to meet the ampled patients presenting for			emergency department areas, incl their qualifications and scope of du		
	evaluation of an em	ergency medical condition. (assignment. (Attachment D)		
		E, F, G, H, I, J, K, L, M, N, O,			Historical volume data (e.g., cens	us) are	
	P, Q). The hospital i	ailed to:			used to establish the staffing requ	irements.	6/19/07
		es and procedures (P&P), by-			Nursing management has access uses an automated system to adi		0,13,01
		lations developed to ensure			required staffing on a shift-by-shift		
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		agment was provided in a			adjustments on a shift-by-shift bar Pediatrics Urgent Care Director o		
	timely manner,	·			Pediatrics maintains a schedule o	f the	
	4. Provide stabilizing	treatment for emergency			physician staffing needs and he/s responsible for adjustments on a :		
	medical conditions.				shift basis. The Department of Wo		
		nsfer of individuals who			and Child's Health is independent		'
	required services no	t available at the hospital.		ļ	responsible for the services. Rost qualified personnel are maintaine		
	The cumulative effe	ct of these systemic failures		ŀ	responsible managers.		
<u>i</u>		ER/SUPPLIER REPRESENTATIVE'S SIGN	IATI IDE		TITLE	<u>_</u>	(X6) DATE

Any deficiency/statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 455	The following reflect Department of Heal investigation of EM Representing the D JoAnn Dalby, R.N., Supervisor Senford Weinstein, Barbara Mellor, R.N. Nurse 482.55(a)(2) INTEG SERVICES The services must be departments of the This STANDARD is Based on observation review, the hospital provision of emergeneeds of 17 of 60 seevaluation of an em Patients A, B, C, D, P, Q). The hospital 1. Follow their policillaws, rules and regumedical screening eby appropriately quation 1. Ensure on - call proposed pages of 17 of 60 seevaluation of an empatients A, B, C, D, P, Q). The hospital 1. Follow their policillaws, rules and regumedical screening eby appropriately quations. Ensure pain manatimely manner, 4. Provide stabilizing medical conditions. 5. Ensure timely trarrequired services not seevaluated services not service	ts the findings of the lith Services during TALA complaint # 117102. epartment of Health Services: Health Facilties Evaluator M.D., Medical Consultant L., Health Facilities Evaluator RATION OF EMERGENCY De integrated with other hospital. Sonot met as evidenced by: Don, interview and record failed to ensure the timely not services to meet the ampled patients presenting for ergency medical condition. (E. F. G. H. I. J. K. L. M. N. O. failed to: es and procedures (P&P), by lations developed to ensure examinations were conducted diffied individuals. hysicians saw patients when in was required. Engment was provided in a greatment for emergency insfer of individuals who it available at the hospital.			A000 (continued) METHOD/PROCESS ACCOUNTING INDIVIDUALS SEEKING EMERGENOUSERVICES e. As part of the triage process, ea individual seeking emergency meriage window and is manually to a licensed nurse, as well as is enthe emergency room central log registration clerk. At that point, perovided with an Identification with they maintain until their discrepancy in the emergency treatment by registered nurse who notifies registration staff. Registration staff and the patient is identification wristband. As a way to assure that all patients are by this process, the nursing shift superincludes the ED waiting room on shift reach shift. The Nursing Shift Supervisor two patients in the waiting room and vathat these two patients have been approand timely triaged and that each patient been entered in to the central log. In the that discrepancies are discovered, immorrective actions are taken. To assure that each of the correction and iscussed below are fully implemented monitored, the Director of Quality Improving track each corrective action, and reher findings to the Quality Council. The Council reports its findings and follow-up to both the Executive Committee and the Governing Body.	ch edical to the egged in by ntered into by the eatients are eistband, scharge. e are nent area the eff enters d then into given an ecaptured visor ounds or selects lidates opriately t has e event lediate ctions and overnent port on Quality p actions	6/19/07 5/16/07
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	countersigned by the physician at 1900 he provided by the neu record failed to contitue neurologist had. This finding was in values and regulation. The consultation red MAC transfer to a faservice was required. A written order for "I facility was provided attending ED physic written documentation actually spoken with clinical situation of Preceiving hospital to A. Documents contained that Patien on 2/28/07. At 0350 hours on Marevealed that Patien on 2/28/07. At 0350 hours on Marevealed that Patien (narcotic pain medic push). There was not ED physician had experienced that Patien (narcotic pain medic push). There was not ED physician had experienced assessment perform that a neurocheck he headache pain of Patient Or30, 0900,1100, These nursing assessments indicat assessments indicat	ed by the PA-C, was then e attending neurology ours. No written note was rology physician. The medical cain documented evidence that actually examined Patient A. violation of the Medical Staff s requiring a written note. quest form revealed that "Stat actility with neurosurgical	A	455	Managers shall work with MAC to coordinate the transfer via ACLS transport. All appropriate and completed documents and imaging studies accompany the patient. If the ED physician determines the there is ANY impediment to the the he/she shall contact the Chief Me Officer at the receiving facility to facilitate the transfer. With respect to all patient transfer regardless of patient diagnosis, a transfer log is maintained by MLF Patient Flow Manager. A multidisciplinary group meets Mo through Friday to review all transithat have taken place based on the to resolve any issues identified from completed transfers, to facilitate walting for transfer, and to update status of patients requiring transfer will be reviewed as part of process. MLK-H has identified a medical administrative Director in charge patient flow. This Patient Flow Menotifies the medical administrative Director whenever there are impediments to transfering a patincluding a neurosurgical patient, timely manner. The medical administrative Director will assure there is high-level physician control potential receiving institutions in a effort to expedite transfers. Data regardation transfers is aggregated at presented to Performance Improve Committee and to the Executive Committee, and then to the Gove Body where appropriate. Position Responsible: Interim Chief Medical Officer	shall at ransfer, edical as,	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
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	Patient A remained of the medical recor was assessed by no received Dilaudid ar headache pain. The included only a numintensity of pain but radiation, quality (ac burning) and constatestablished hospital failed to provide door physicians provided care. Except for the did not see the patien headache pain. Inters/10. The patient wanor were non-medic Nursing documental deficits were noted. sentence stated c/o when ambulating. The for the neurological state of the patien as being 9/10 (state of the patien or was obtained in patient's medical reconstruction.	in the ED until 3/3/07. Review d revealed that the patient ursing staff and continued to ad morphine to control his nursing pain assessments erical score to identify the failed to identify pain he, throbbing, sharp, dull, ncy as required by policy. The medical record amented evidence that ED on-going assessments and initial consult, the neurologist and again. Ours, nursing documentation at A complained of occipital nsity of pain was recorded as is not given pain medication ation interventions provided. It is not given pain medication ation interventions provided. It is not given pain medication at a complained of increased extra the transity of severe). The patient received pain. Although a physician or the pain medication, the cord failed to contain that the ED physician it.	. A 4	455	Immediate Actions: The Interim Chief Medical Officer all MLK Department Chiefs to dist the practice of using Physician As for consultations in the ED. All ED consultations will be performed by attending physician. (Attachment The ED Nurse Manager provided instructing all ED RNs regarding Physician Assistants cannot provi consults. (Attachment F) The Interim Chief Medical Officer Instructed all Department Chiefs the ensure that all attending physician aware of the need to document the consultations. (Attachment B). Monitoring: For the next 30 days, Monday three Friday, Quality Improvement staff review ten randomly selected opermedical records in the ED to valid consults were performed by a phy and that there is a consulting physical note. The Chair of the relevant department will be notified of discrepancies for immediate correlaction. Ten randomly selected ED recording patients will be reviewed each were validate the presence of the attending note. Results of these audits will be presented to Performance Improving Committee, which will review and corrective actions as necessary. The data will then be reported to the Executive Committee and to the Governing Body as appropriate. The Chair of the service will be notified discrepancies for corrective actions.	continue ssistants) y an E) a letter de ons are eir ough will n ate that sician sician's ective s of ek to dees be ement create his	3/14/07 3/19/07 3/19/07
		they were tired of waiting for					İ

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	AMA (against medical elsewhere. The "Lea Advice" form was not addition, the medical documented evidentischarge, the patie physician or had recomply and 6/5/6 staff regarding the cassurance, identified received by Patient appropriate. The hoprovide any and all opatient's care as we reviews. A case review summer received at 1340 hoprovide any and all opatient's care as we review confirmed at document assessmed document assessmed asse	nospital. Patient A signed out cal advise) to seek treatment aving Hospital against Medical oted to be incomplete. In all record failed to contain ce that at the time of int had been assessed by a seived discharge instructions. Of discussions with hospital care of Patient A and quality dithat the medical care A was deemed to be spital was requested to documentation related to the as any quality of care nary for Patient A was ure on 6/5/07. The case failure of the ED physicians to ents of Patient A for three of the summary identified term wide plan to provide es and to streamline the patients between hospitals. ding transfer to a higher level or to leaving the hospital ice. As of 6/7/07, the plan had ed.	A-455	Immediate Action — Patient A: The ED Nurse Manager counse RN who falled to record the attripain as required by policy. The ED Nurse Manager conduct Inservice training for all ED RNs regarding appropriate document pain assessments and the requision for reassessment of after medical Training was also provided on a documentation standards. (Attachment L) Monitoring: Tracer rounds (a process borrow recognized Joint Survey Commissurvey techniques) are conducted a week. On these rounds, staffing (among other things) medical revalidate pain documentation. Conactions will be initiated for all deficiencies. Aggregated results these audits are presented to the Performance Improvement Comwhich will review and create conactions as appropriate. This data reported to Executive Committee the Governing Body as appropriate Depthysician Director	butes of ted tation of rements ation. lear ved from ssion ed once eview cords to rrective of e mittee, rective a will be e and to	6/19/07
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PRINTED: 06/12/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 050578 06/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LAC/MARTIN LUTHER KING JR GEN HOSPITAL LOS ANGELES, CA 90059 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION * (EACH DEFICIENCY MUST BE PRECEDED BY FULL. *** *** REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH GORRECTIVE ACTION SHOULD BE CROSS-TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE - A 455 Continued From page 5 A 455 Immediate Actions - Patient A: . 6/9/07 The ED Nurse Manager provided, transfer to another hospital. Patient A signed out. education for all ED RNs on discharge AMA (against medical advise) to seek treatment assessments. elsewhere. The "Leaving Hospital against Medical The ED Medical Director provided 6/5/07 education to ED MDs on the elopement Advice" form was noted to be incomplete. In and AMA policy, which includes the addition, the medical record failed to contain requirement to document the patient's documented evidence that at the time of level of capacity and the discussion with discharge, the patient had been assessed by a the patient regarding the risks and physician or had received discharge instructions. benefits. The education addressed that patients should be provided with instructions for follow-up care. On 6/1/07 and 6/5/07 discussions with hospital (Attachment K.) staff regarding the care of Patient A and quality assurance, identified that the medical care Monitoring: Ten randomly selected charts will be received by Patient A was deemed to be reviewed each week to validate completion of appropriate. The hospital was requested to discharge assessments by MDs and RNs. provide any and all documentation related to the Deficiencies will be discussed with the patient's care as well as any quality of care appropriate supervisor and results will be reported to Performance Improvement reviews. Committee, which will review and create corrective action as necessary. This data will A case review summary for Patient A was then be reported to the Executive Committee received at 1340 hours on 6/5/07. The case and to the Governing Body as appropriate. review confirmed a failure of the ED physicians to Position Responsible: document assessments of Patient A for three ED Nurse Manager days. Further review of the summary identified ED Medical Director that there was a system wide plan to provide neurosurgical services and to streamline the transfer process of patients between hospitals. Patient A was a pending transfer to a higher level of care on 3/3/07 prior to leaving the hospital against medical advice. As of 6/7/07, the plan had not been implemented. Immediate Actions - Patient B: 2. Patient B presented to the emergency When patient B is specifically identified 6/21/07 through a list provided by CMS, the nurse department on 3/8/07 at 2242 hours, with a chief who triaged this patient as a Level 3 will be complaint of stomach pain for the past two weeks re-educated regarding the assignment of this

. The nurse documented that the pain was in all

multiple episodes of nausea and vomiting today.

The patient identified her pain as being severe

four quadrants and radiated in to the patient's

back. It was documented that the patient had

triage level.

(Attachment M)

The ED Nurse Manager will provide re-

is consistent with their presentation.

education to all ED RNs on the requirements to classify patients into a triage category that

6/21/07

NAME OF PROVIDER OR SUPPLIER LAC/MARTIN LUTHER KING JR GEN HOSPITAL SUMMARY STATEMENT OF DEFICIENCES (EACH DEPICIENCY MIST BE PRECEDED BY PULL PROVIDERS PLAN OF CORRECTION PREFER TAGE A 455 Continued From page 6 with a score of 10 out of 10. The patient identified that the pain she was experiencing was constant and that nothing provided relief. The pain was further described as aching and burning with a pressure sensation. Nursing documentation revealed that the patient was moaning and had facial grimacing. Vital signs were recorded as Temperature 102.8 degrees, heart rate 97, respirations 24 and blood pressure was 133/59. No treatment was provided to alleviate pain or reduce the patient sear described as having a stable major injury or illness. Two hours later, at 0040 hours, Patient B's vital signs were reassesed. The patient toollinued to experience as 118/62. The patient continued to experience severe abdominal pain. No treatments were provided in the triage area. At 0110 hours, the patient was transferred to the treatment area. The patient toollinued to experience severe abdominal pain. No treatments were provided in the triage area. At 0110 hours, the patient was transferred to the treatment area. The patient was described to have decreased pain. At 0400 hours, nursing documentation revealed that the patient had no orders for corace and was waiting for the physician assistant. This was approximately three hours after she was taken to the treatment area of the ED. Patient B was not evaluated by a physician until a patient before the physician assistant. This was approximately three hours after she was taken to the treatment area. The patient had no orders for care and was waiting for the physician assistant. This was approximately three hours after she was taken to the treatment area of the ED. Patient B was not evaluated by a physician until a patient before the physician assistant. This was approximately three hours after she was taken to the treatment area. The patient had no orders for care an	1		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION	(X3) DATE S	
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A 455 Continued From page 6 with a score of 10 out of 10. The patient identified that the pain she was experiencing was constant and that nothing provided relief. The pain was further described as aching and burning with a pressure sensation. Nursing documentation revealed that the patient was moaning and had facial grimacing. Vital signs were recorded as Temperature 10.2.8 degrees, heart rate 97, respirations 24 and blood pressure was 133/59. No treatment was provided to alleviate pain or reduce the patient's easing at tinge category of 3. Category or Level 3 patients are described as having a stable major injury or illness. Two hours later, at 0040 hours, Patient B's vital signs were re-assessed. The patient had a temperature of 102.4 degrees, heart rate 102, respirations 20 and blood pressure was recorded as 118/62. The patient continued to experience severe abdominal pain. No treatments were provided in the triage area. At 0110 hours, the patient was transferred to the treatment area. The patient was described to have decreased pain. At 0400 hours, nursing documentation revealed that the patient had no orders for care and was waiting for the physician assistant. This was approximately three hours after she was taken to the treatment area of the ED. Patient B was not evaluated by a physician until patient with a sorreing to a possible. If	Ì			R GEN HOSPITAL	:	12021 S WILMINGTON AVE	, 55/5	172001
with a score of 10 out of 10. The patient identified that the pain she was experiencing was constant and that nothing provided relief. The pain was further described as aching and burning with a pressure sensation. Nursing documentation revealed that the patient was moaning and had facial grimacing. Vital signs were recorded as Temperature 102.8 degrees, heart rate 97, respirations 24 and blood pressure was 133/59. No treatment was provided to alleviate pain or reduce the patient's fever at the time of triage. The patient was assigned a triage category of 3. Category or Level 3 patients are described as having a stable major injury or illness. Two hours later, at 0040 hours, Patient B's vital signs were re-assessed. The patient had a temperature of 102.4 degrees, heart rate 102, respirations 20 and blood pressure was recorded as 118/62. The patient continued to experience severe abdominal pain. No treatments were provided in the triage area. At 0110 hours, the patient was transferred to the treatment area. The patient continued to have severe pain, recorded as 710. The patient received Tylenol 650 mg, and was placed on oxygen by mask. At 0220 hours, the patient was described to have decreased pain, At 0400 hours, nursing documentation revealed that the patient had no orders for care and was waiting to the physician assistant. This was approximately three hours after she was taken to the treatment area of the ED.		PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX **	FINE TEACH CORRECTIVE ACTION SHOULD	BE CROSS-	(XS) COMPLETION DATE
a patient's condition is critical, the a fever and was in moderate to severe distress. The patient continued to experience severe pain The patient continued to experience severe pain The patient continued to experience severe pain The patient's condition is critical, the RN will verbally notify the physician.			with a score of 10 or that the pain she was and that nothing profurther described as pressure sensation. revealed that the passive sensation. revealed that the passive sensitions of the passive sensitions of the passive sensitions of the patient was associated by the patient was not even of the ED.	ut of 10. The patient identified as experiencing was constant ovided relief. The pain was aching and burning with a Nursing documentation attent was moaning and had al signs were recorded as degrees, heart rate 97, blood pressure was 133/59. To vided to alleviate pain or fever at the time of triage. Signed a triage category of 3. patients are described as or injury or illness. 2040 hours, Patient B's vital used. The patient had a 4 degrees, heart rate 102, blood pressure was recorded ent continued to experience ain. No treatments were earea. 2041 and was placed on 0220 hours, the patient on 0220 hours, the patient was ecreased pain. At 0400 hours, for revealed that the patient re and was waiting for the This was approximately a was taken to the treatment reluated by a physician until ent was described as having noderate to severe distress.	A 455	The ED Nurse Manager provided to all ED RNs on the requirement in physicians of all patients waiting to that are experiencing pain at a lew requires intervention based on the policy. This information must be do in the patient's medical record. (At L) A multidisciplinary team of ED phy and ED nurses reviewed the currer process. As a result of that review, triaging process was re-designed for a more timely medical screening. (Attachment O) The triage nurse and registration process and the registration process and the registration process can simultaneously. A physician will be available triaging area to perform medical screening examination pain managements who are identified level 3. Upon completion medical screening examination, tests and to presentation, tests and to present the patient's prought back to the mergency treatment and time of arrival, the ED of will notify the physician of patient's pseudo name of patient's condition is condition.	education on otify of the seen pain pocumented tachment sicians and triage the opprovide gram. It is interested to the immediate inations for ed as a of the ination, in inical reatments ment) will but, ed as a e of triage ne ea. At the harge nurse of the ination, in inical reatments ment, will but, ed as a e of triage ne ea. At the harge nurse of the inition, in the white ient's sician will by and will seening possible. If ritical, the	6/21/07

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A 455	throughout her ED s At 0950 hours, 11 h ED, the patient was	tient experienced severe pain	A 4	155	Monitoring: Ten randomly selected medical records will be reviewed daily to the time from triage to medical screening examination. Data from these daily reviews will be presenthe ED Collaborative Practice Committee and the process will be evaluated as a result of this review Data will also be presented to the Performance Improvement Commmonthly which will evaluate it, crecorrective actions as necessary, a report it to the Executive Committe and as appropriate, the Governing Body.	ted to e re- w. sittee ate and ee	
	the teenager present department (ED) at right abdominal pair nurse and determine 10 scale (10/10). His pulse 95 is blood pressure was nurse documented to difficulty breathing. It had wheezing in his was 22, blood pressure was saturation was 97% restless. There was he was left in the lob medication or other were provided. The the patient until he will be hours later. At 0 pain was 8/10. At 0 and pain medication The pain medication The pain medication hours; approximately presented to the ED were not available un approximately 14 ho and 19 hours after Presented to the pain medication and 19 hours after Presented to the ED were not available un approximately 14 ho and 19 hours after Presented to the ED were not available un approximately 14 ho and 19 hours after Presented to the ED were not available un approximately 14 ho and 19 hours after Presented to the ED were not available un approximately 14 ho and 19 hours after Presented to the ED were not available un approximately 14 ho and 19 hours after Presented to the ED were not available un approximately 14 ho and 19 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not available un approximately 14 hours after Presented to the ED were not	ord for Patient D documented ted to the emergency 2355 hours on 2/12/07 with the ed to have pain of 10 on a 1-s oxygen saturation level was respirations were 18 and his 113/69. At 0040 hours the he patient was complaining of the nurse documented he lungs, his respiratory rate sure was 135/70, oxygen and that he was anxious and no documentation about why by of the ED. No pain pain relieving interventions re was no re-assessment of the staken to a treatment area 1530 hours on 2/13/07 his was administered at 0840 at 8 and 1/2 hours after he The laboratory test results after they were ordered atient D came to the ED. The nented evidence the nursing		•	Position Responsible: ED Medical Director ED Nurse Manager Immediate Actions – Patient D: The ED Nurse Manager provided to all ED RNs on the requirement physicians of all patients waiting that are experiencing pain, which interventions based on the pain p A multidisciplinary team of ED ph ED nurses reviewed the current to process. As a result of that review triaging process was re-designed for a more timely medical screeni examination. This process include following: The triage nurse and reclerk are co-located so triaging process and the registration process car simultaneously. A physician will be avaitable triaging area to perform medical screening exam patients who are identificated in the patient's concept to presentation, tests and (including pain manage be ordered and carried or Patients who are identificated in the patients who are identificated	to notify to be seen requires olicy. yelloins and riage v. the to provide ng es the gistration that the n occur lable to the immediate ninations for ied as a n of the nination, clinical treatments ment) will out. ied as a	6/19/07 6/21/07

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	ED, the patient was services to undergo	transferred to surgery an exploratory laparotomy.			perform the medical screening examination as soon as possib patient's condition is critical, th verbally notify the physician. The ED Nurse Manager will provide education for all ED RNs on the nee reassess triaged patients in the ED room, based on their acuity and acc	ole. If a se RN will re- ed to waiting cording to	6/11/07
•	the teenager present department (ED) at a right abdominal pain nurse and determine 10 scale (10/10). His pulse 95 reblood pressure was nurse documented to difficulty breathing. Thad wheezing in his was 22, blood pressure attration was 97% restless. There was he was left in the lob medication or other pwere provided. There the patient until he will five hours later. At 0 pain was 8/10. At 06	ord for Patient D documented ted to the emergency 2355 hours on 2/12/07 with . He was triaged by the ed to have pain of 10 on a 1-s oxygen saturation level was espirations were 18 and his 113/69. At 0040 hours the ne patient was complaining of the nurse documented he lungs, his respiratory rate cure was 135/70, oxygen and that he was anxious and no documentation about why by of the ED. No pain pain relieving interventions was no re-assessment of as taken to a treatment area 530 hours on 2/13/07 his sat hours laboratory tests			the triage policy number 114. (Attack A multidisciplinary team of Nursing, Pathology reviewed the current producting, collecting and delivering is ED. The process was re-designed to the following: (Attachment O) o All laboratory orders are entry system. The Labora Supervisor prints a list of tests and reviews the order list every hour. o A laboratory runner goes every 30 minutes collects specimens and follow-up ordered specimens that an available for retrieval. If la not been received in the le one hour, the lab sends si to collect sample. o The ED Nurse Manager p re-education for all ED RM responsibility to follow-up outstanding lab results.	ehment P) ED and cesses for abs for the o include entered in order tory ordered ers on this to the ED the lab on any re not abs within omeone rovided so on their	6/21/07
	and pain medication The pain medication hours; approximately presented to the ED, were not available ur approximately 14 hor and 19 hours after P	were ordered for Patient D. was administered at 0840 8 and 1/2 hours after he The laboratory test results atil 2100 hours. This was ars after they were ordered atient D came to the ED. mented evidence the nursing			Monitoring: Ten randomly selected medical receive be reviewed daily to track the time for to medical screening examination. If these daily reviews will be presented ED Collaborative Practice Committed process will be re-evaluated as a result of this review. Data will also be presented the process will be provied the process of the province improvement Committed which will evaluate it, creative actions as necessary and corrective actions as necessary and provinced the process of the provinced the prov	rom triage Data from d to the ee and the sult of sted to the ee	·

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3. The medical rectine teenager preser department (ED) at right abdominal pair nurse and determine 10 scale (10/10). He scale (10/10). He scale (10/10). He scale (10/10). He scale (10/10) he patient until he with the local until he with the patient until he with the local until he with the	an exploratory laparotomy. ord for Patient D documented ated to the emergency 2355 hours on 2/12/07 with a. He was triaged by the ed to have pain of 10 on a 1-les oxygen saturation level was respirations were 18 and his 113/69. At 0040 hours the he patient was complaining of the nurse documented he lungs, his respiratory rate sure was 135/70, oxygen and that he was anxious and a no documentation about why aby of the ED. No pain pain relieving interventions re was no re-assessment of was taken to a treatment area 0530 hours on 2/13/07 his were ordered for Patient D. was administered at 0840 y 8 and 1/2 hours after he The laboratory test results ntil 2100 hours. This was urrs after they were ordered		assurance program, the time from the time of receipt of specimen wil tracked and trended and corrective based on the data will be recomme the Quality Improvement Committe reported to the Executive Committe Governing Body as appropriate. Ten randomly selected open medi- will be reviewed each week to trace from when the labs are ordered to quality improvement activities will immediately add reassess prolong with the RN assigned and the ED Manager for immediate actions, th are placed in the chart. Results of audits will be reported to the Perfo Improvement Committee which wil and create corrective actions as no	request to l be e actions ended to se, then ee and the cal records k the time the time the time ed times Nurse e results these rmance l review ecessary.	
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From parand nausea. The parand nausea. The parand nausea throughout her ED state and nausea to undergo 3. The medical recompany of the patient was services to undergo 3. The medical recompany of the patient was services to undergo 3. The medical recompany of the patient was services to undergo 3. The medical recompany of the patient was services to undergo 3. The medical recompany of the patient was services to undergo 3. The medical recompany of the patient (ED) at the patient was end determined to scale (10/10). His pulse 95 to blood pressure was not set the patient until he was set the patient until he was set to the patient unti	CORRECTION IDENTIFICATION NUMBER:	TONDER OR SUPPLIER TIN LUTHER KING JR GEN HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED, BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 455 Continued From page 7 and nausea. The patient experienced severe pain throughout her ED stay. At 0950 hours, 11 hours after presenting to the ED, the patient was transferred to surgery services to undergo an exploratory laparotomy. 3. The medical record for Patient D documented the teenager presented to the emergency department (ED) at 2355 hours on 2/12/07 with hight abdominal pain. He was triaged by the nurse and determined to have pain of 10 on a 1-10 scale (10/10). His oxygen saturation level was 100%, his pulse 95 respirations were 18 and his blood pressure was 113/69. At 0040 hours the nurse documented the patient was complaining of difficulty breathing. The nurse documented he had wheezing in his lungs, his respiratory rate was 22, blood pressure was 135/70, oxygen saturation was 97% and that he was anxious and restless. There was no documentation about why he was left in the lobby of the ED. No pain medication or other pain relieving interventions were provided. There was no re-assessment of he patient until he was taken to a treatment area ive hours later. At 0530 hours on 2/13/07 his bain was 8/10. At 0645 hours laboratory tests and pain medication were ordered for Patient D. The pain medication was administered at 0840 hours; approximately 8 and 1/2 hours after he oresented to the ED. The laboratory test results were not available until 2100 hours. This was approximately 14 hours after they were ordered and 19 hours after Patient D came to the ED.	DENTIFICATION NUMBER: DS0578 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	A BUILDING DONDER OR SUPPLIER TIN LUTHER KING UR GEN HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LOSA ANGELES, CA 90059 SUMMARY STATEMENT OF DEPICIENCIES GRACH DEFICIENCY MUST SEPPRECEIBLES YELL REGULATORY OR US DENTIFYING INFORMATION) Confinued From page 7 and nausea. The patient experienced severe pain throughout her ED stay. At 0950 hours, 11 hours after presenting to the ED, the patient was transferred to surgery services to undergo an exploratory laparotomy. At 0950 hours, 11 hours after presenting to the teenager presented to the emergency separtment (ED) at 2355 hours on 2/12/07 with girl abdominal pain. He was triaged by the rurse and determined to have path of 10 on a 1-10 scale (10/10). His oxygen saturation level was 100%, his pulse 95 respirations were 18 and his locd pressure was 113/69. At 0040 hours the rurse documented he had wheezing in his lungs, his respiratory rate was 2, blood pressure was 135/70, oxygen saturation evel was administered to the ED. Street ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LOSA ANGELES, CA 90059 PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 455 A 5719/0 A 57

NAME OF PROVIDER OR SUPPLIER LAC/MARTIN LUTHER KING JR GEN HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LOS ANGELES, CA 90059 (X4) ID PRIETIX- (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 455 Continued From page 8 or medical staff were following-up to ensure the laboratory test results were obtained. During interviews on 6/1/07 medical staff stated this patient "fell through the cracks." A 4. a. The medical record for pediatric Patient C showed she presented to the emergency department at 1030 hours on 3/20/07 for vomitting, lethargy, cough and congestion. She had a history of a ventriculoperitoneal shunt for hydrocephalus and began to feel bad after a visit to the dentist. Documentation shows the		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION (X3) DATE S COMPL		
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PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 455 Continued From page 8 or medical staff were following-up to ensure the laboratory test results were obtained. During interviews on 6/1/07 medical staff stated this patient "fell through the cracks." 4. a. The medical record for pediatric Patient C showed she presented to the emergency department at 1030 hours on 3/20/07 for vomiting, lethargy, cough and congestion. She had a history of a ventriculoperitoneal shunt for hydrocephalus and began to feel bad after a visit to the dentist. Documentation shows the		·	R GEN HOSPITAL	I	1	12021 S WILMINGTON AVE	1 00/0	772007
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presence of a shunt malformation and/or infection was being ruled out. A neurology consult was ordered. At 1230 the physician's assistant (PA) saw the patient to perform the neurology consultation. There was no documented evidence a neurologist saw the patient, however, the PA documented the recommended plan, in consultation with the neurologist, would be evaluation and management by a neurosurgeon on an urgent basis to assess the functioning of the shunt. Since neurosurgeons were not available at the hospital the PA recommended transfer to another hospital. The child was in the emergency department until 2200 hours but there was no documented evidence a neurosurgeon was contacted or that efforts were made to transfer the patient to a hospital with this service available. The patient was discharged to the mother's care. 4. b. At 1215 hours on 3/20/07 radiological tests of Patient C's shunt was ordered. Documentation shows the patient went to x-ray at 1325 hours but the tests were not performed because the radiology department did not know what to do. At 1415 hours the patient was again sent to the radiology department for the tests. The test		or medical staff wer laboratory test result interviews on 6/1/07 patient "fell through 4. a. The medical reshowed she preser department at 1030 vomiting, lethargy, of had a history of a very hydrocephalus and to the dentist. Documented to the dentist. Documented out. Ordered. At 1230 the saw the patient to presence a neurolog the PA documented consultation. There evidence a neurolog the PA documented consultation with the evaluation and man on an urgent basis to the shunt. Since ne available at the host transfer to another hemergency department was no documented was contacted or that transfer the patient to available. The patient of Patient C's shunt shows the patient with the tests were not per radiology department 1415 hours the patient with the patient with the patient with the patient with the tests were not per radiology department 1415 hours the patient with the patient w	re following-up to ensure the lits were obtained. During medical staff stated this the cracks." ecord for pediatric Patient Conted to the emergency hours on 3/20/07 for sough and congestion. She entriculoperitoneal shunt for began to feel bad after a visit imentation shows the malformation and/or infection. A neurology consult was e physician's assistant (PA) erform the neurology was no documented plan, in eneurologist, would be agement by a neurosurgeon of assess the functioning of urosurgeons were not contact the PA recommended nospital. The child was in the ent until 2200 hours but there is evidence a neurosurgeon at efforts were made to no a hospital with this service and the service of a hospital with this service on the service of the service o	A	455	Immediate Action — Patient C: The Interim Medical Director direct chairs of the Department of Medici Women's and Child Health and Su physician assistants will no longer conducting medical consultations in (Attachment R) It was determined that there was no need for neurosurgical transfer base results on of the shunt series, but the not clearly documented. The Chair Department of Women's and Child will counsel this physician on the ladocumentation of the change in tree plan. Monitoring: For the next 30 days, Monday through the ED to validate that consults were performed by a physician and that consulting physician's note. The Chresponsible Department will be not discrepancies for immediate correct actions. Ten randomly selected ED records patients who received a consult, included that all consults were performed by a physician and that there is a consult physician and that there is a consul	ne, rgery that be not the ED. o longer a sed on the his was of sed of clear atment with the ED. ugh Friday, when there is a hair of the fifted of cluding seek to or med by a liting esponsible espancies ese audits. I review essary.	6/19/07

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	· · · · · · · · · · · · · · · · · · ·	e following-up to ensure the			t the state of the		14 (Fig. 1971)
	laboratory test resu	its were obtained. During medical staff stated this			· • • • • • • • • • • • • • • • • • • •	•	
-	showed she preser department at 1030 vomiting, lethargy, of had a history of a ver hydrocephalus and to the dentist. Docu presence of a shund	ecord for pediatric Patient C Inted to the emergency Industry on 3/20/07 for Cough and congestion. She Entriculoperitoneal shunt for began to feel bad after a visit Imentation shows the I malformation and/or infection I A neurology consult was			Immediate Action – Patient C: o The patient received the shunt series ordered by the physician and want into the computerized order entry series available via the computerized radiosystem at 1426.	as entered system at es were	6/18/07
٠	ordered. At 1230 the saw the patient to p consultation. There evidence a neurolog the PA documented consultation with the	er physician's assistant (PA) erform the neurology was no documented gist saw the patient; however, the recommended plan, in e neurologist, would be agement by a neurosurgeon			At 1435 the patient was transferre radiology for an additional test, a control of the Nurse Manager of Women's at Health will provide inservice training proper documentation to avoid misentries to all nursing staff.	CT scan. nd Child g on the	6/18/07
	on an urgent basis if the shunt. Since ne available at the host transfer to another if emergency departments are contacted or the transfer the patient.	to assess the functioning of curosurgeons were not pital the PA recommended nospital. The child was in the lent until 2200 hours but there it evidence a neurosurgeon at efforts were made to to a hospital with this service ent was discharged to the			Monitoring: Ten randomly selected ED medical reco reviewed each week to assure clear documentation of patient care events. R this audit will be presented to the Perfor Management Committee which will revie create corrective actions as necessary. will then be reported to the Executive Co Position Responsible: Chief Nursing Officer	esults of mance w and The data	•.
	of Patient C's shunt shows the patient w the tests were not p radiology departmen 1415 hours the patie	on 3/20/07 radiological tests was ordered. Documentation ent to x-ray at 1325 hours but erformed because the at did not know what to do. At ent was again sent to the at for the tests. The test					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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"spotting" during he was 2 months pregr triaged and a pregn positive. When the	r pregnancy. She stated she nant. At 2140 hours she was ancy test was documented as patient was called to the urs later, she had left without						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 050578 06/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LAC/MARTIN LUTHER KING JR GEN HOSPITAL LOS ANGELES, CA 90059 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE CROSS-COMPLETION · REGULATORY OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG TAG · A 455 Continued From page 9 the transfer of the A 455 results were not available for diagnosis and/or J. 10 1 1 1 1 1 treatment until 1700 hours; 6 and 1/2 hours after Patient C presented to the ED. Monitoring: Ten randomly selected medical records will be reviewed daily to track the time from triage to 5. The medical record for Patient E documented medical screening examination. Data from he presented to the ED at 1139 hours on 5/11/07 these daily reviews will be presented to the ED with left flank pain. He was not seen by a triage Collaborative Practice Committee and the process will be re-evaluated as a result of this nurse until three hours later to determine the review. Data will also be presented to the severity of his symptoms. At 1448 hours, the Performance Improvement Committee monthly triage nurse documented his pain was 8/10. At which will evaluate it, develop corrective actions 1730 hours the nurse documented the first full as necessary, and report it to the Executive assessment of the patient. The patient was Committee and as appropriate to the governing Body. Once the Executive Committee evaluated by a physician's assistant. There was concludes that the process is stable, the daily no documented evidence a physician saw Patient record review will convert to a monthly review. E. Pain medication was not administered to Position Responsible: Patient E until 2100 hours, 9 and 1/2 hours after **ED Medical Director** he presented to the ER. No further treatment ED Nurse Manager was provided to Patient E and it was documented that he eloped from the ED at 0000 hours on 5/12 /07. The medical record for Patient F identified that he came to the ED at 1812 hours on 5/11/07 for a "surgical consult for (his) umbilical hernia." He was triaged at 1845 and complained of 5/10 pain. When he was called to the treatment area four hours later he did not answer. At 0100 the nurse documented the patient left without being seen. No medical screening examination had been performed to determine if the patient had a medical emergency condition. 7. The medical record for Patient G showed she presented to the ED at 2045 hours on 5/11/07 for "spotting" during her pregnancy. She stated she was 2 months pregnant. At 2140 hours she was

triaged and a pregnancy test was documented as positive. When the patient was called to the treatment area 2 hours later, she had left without

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A 455	results were not avatreatment until 1700 Patient C presented 5. The medical recibe presented to the with left flank pain. nurse until three hoseverity of his symptriage nurse documinated evides assessment of the prevaluated by a physical patient E until 2100 he presented to the was provided to Patient E until 2100 he presented to the was provided to Patient He eloped from 1/07. 6. The medical recibe came to the ED a surgical consult for was triaged at 1845 When he was called hours later he did not documented the par No medical screening performed to determine the string the string to determine the string th	ailable for diagnosis and/or hours; 6 and 1/2 hours after to the ED. ord for Patient E documented ED at 1139 hours on 5/11/07 He was not seen by a triage urs later to determine the toms. At 1448 hours, the ented his pain was 8/10. At see documented the first full patient. The patient was lence a physician saw Patient was not administered to hours, 9 and 1/2 hours after ER. No further treatment lent E and it was documented the ED at 0000 hours on 5/12 ord for Patient F identified that at 1812 hours on 5/11/07 for a (his) umbilical hernia." He and complained of 5/10 pain. It to the treatment area four of answer. At 0100 the nurse ient left without being seen. In gexamination had been hine if the patient had a	A	455	Immediate Actions — Patient G: A multidisciplinary team of ED and ED nurses reviewed the coprocess. As a result of that reviriaging process was re-design for a more timely medical screexamination. This process inclifoliowing: The triage nurse and clerk are co-located triaging process and registration process simultaneously. A physician will be a triaging area to performedical screening expatients who are ideal level 3. Upon complemedical screening expatients who are ideal evel 3. Upon complemedical screening expatients who are ideal evel 1 and 2 at the will be brought back emergency treatmen time of arrival, the El will notify the physicipatient's arrival by platient's pseudo namboard along with the priority number. The acknowledge the patinitialing the white be perform the medical examination as soon	physicians urrent triage iew, the ed to provide ening udes the registration so that the the can occur vailable to the rm immediate aminations for tiffied as a tion of the camination, s clinical and treatments gement) will ed out. Tiffied as a lime of triage to the tarea. At the charge nurse an of the tarea of the tare on the white patient's physician will ent by ard and will screening	6/21/07
	presented to the ED spotting during he was 2 months pregretriaged and a pregnerositive. When the	ord for Patient G showed she at 2045 hours on 5/11/07 for pregnancy. She stated she hant. At 2140 hours she was ancy test was called to the urs later, she had left without			a patient's condition RN will verbally notify physician. The ED Nurse Manager will co registered nurse who did not er amount of bleeding. The Chief Medical Officer notifi Medical Director that physician shall no longer perform medica examinations. (Attachment A). The ED Medical Director inform	s critical, the the unsel the valuate the ED assistants is screening	6/21/07

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES): 06/12/2007
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	being seen to determ condition existed. \$1306 hours on 5/14/bleeding for three detriaged by the nurse documented evidenchow much the patier taken to the treatme at 1730 hours. No pwas given. Her med conducted by a physician at 2235 homiscarriage. 8. Patient O came to 30/07 at approximate triaged at 1250 hours sharp pain of 10 on a intervention were init patient was taken to later at 1815 and rechour later. Approximpresented to the ED, general surgery consevaluate the acute al The closed medical revealed that the ger had been provided by C). There was no do provision of emergent was approved and co regulations, the medical practitioner. The closel practitioner. The closel practitioner.	chine if an emergency She returned to the ED at O7 with a complaint of vaginal ays. She had 8/10 pain when at 1315. There was no be the ED nurse evaluated at was bleeding. She was not at area until four hours later ain medication/intervention lical screening exam was dician's assistant. She of conception while having and was discharged by a aurs after having had a O the ED of the hospital on 4/ ely 1207 hours. When a 1-10 scale. No pain diated in the triage area. The athe treatment area five hours elved pain medication one dately 20 hours after she at 0830 hours on 5/1/07, a cultation was provided to obdominal pain for Patient O. decord for Patient O revealed deral surgery consultation by a Physician Assistant (PA- consistent with the rules and cal staff bylaws of the dentialing process of a mid-		455	!	e from triage Data from ted to the ttee and the result of ented to the ittee velop und report it s Once the	

A 455 Continued From page 10 .A 455		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU		IG	COMPLE	TED
MAME OF PROVIDEA OR SUPPLIER LAC/MARTIN LUTHER KING JR GEN HOSPITAL PARTY TAGE SULMARY STATEMENT OF DEFICIENCIES (EQUIDATION OF DEFICIENCIES) GENUMARY STATEMENT OF DEFICIENCIES (EQUIDATION OF DEFICIENCIES) GENUMARY STATEMENT OF DEFICIENCIES (EQUIDATION OF DEFICIENCY) GENUMARY STATEMENT OF DEFICIENCIES (EQUIDATION OF DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) A 455 Continued From page 10 being seen to determine if an emergency condition existed. She returned to the ED at 1306 hours on 5/14/07 with a complaint of veginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. She was not taken to the treatment area until four hours later at 1730 hours. No pain medication/intervention was given. Her medical screening exam was conducted by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician at 223 hours after having had a miscarriage. 8. Patient O came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours she identified she had sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 67/107, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient O. The closed			050578	B. Wil	/G_		1	
CAMBRITH LUTHER KING JR GEN HOSPITAL CAMBRID SUMMARY STATEMENT OF DEFICIENCIES TEACH DEFICIENCY MUST are PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTTON (CAMPRITHE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CAMPRITHE TAG	NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·					
A 455 Continued From page 10 being seen to determine if an emergency condition existed. She returned to the ED at 1306 hours on 5/14/07 with a complaint of vaginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. She was not taken to the treatment area until four hours later at 1730 hours. No pain medication/intervention was given. Her medical screening exam was conducted by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician at 2235 hours after having had a miscarriage. 8. Patient O came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours she identified she had sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 51/107, a general surgery consultation was provided to evaluate the acute adominal pain for Patient O revealed "Dr," at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). There was no documentation to reveal that provision of emergency consultations by a PA-C	LAC/MAI	RTIN LUTHER KING J	R GEN HOSPITAL			•		
being seen to determine if an emergency condition existed. She returned to the ED at 1306 hours on 5/14/07 with a complaint of vaginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. She was not taken to the treatment area until four hours later at 1730 hours. No pain medication/intervention was given. Her medical screening exam was conducted by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician at 2235 hours after having had a miscarriage. 8. Patient O came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours she identified she had sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 5/107, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient O. The closed medical record for Patient O. The closed medical record for Patient O. The revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). There was no documentation to reveal that provision of emergency consultation by a PA-C	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD	BE CROSS-	(X5) COMPLETION DATE
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regulations, the medical staff bylaws of the hospital, and the credentialing process of a mid-level practitioner. The patient was admitted to the hospital and had surgery for an exploratory laparotomy ventral hernia repair.		being seen to deter condition existed. 1306 hours on 5/14 bleeding for three d triaged by the nurse documented eviden how much the patie taken to the treatme at 1730 hours. No was given. Her me conducted by a phy passed the product an ultrasound done physician at 2235 h miscarriage. 8. Patient O came 30/07 at approximatriaged at 1250 hou sharp pain of 10 on intervention were in patient was taken to later at 1815 and rehour later. Approximate the acute at 1815 and rehour later, approvided C). There was no control of emergence was approved and cregulations, the methospital, and the crelevel practitioner. Thospital and had su	mine if an emergency She returned to the ED at /07 with a complaint of vaginal ays. She had 8/10 pain when at 1315. There was no be the ED nurse evaluated int was bleeding. She was not ent area until four hours later pain medication/intervention dical screening exam was sician's assistant. She is of conception while having and was discharged by a ours after having had a to the ED of the hospital on 4/ tely 1207 hours. When it is she identified she had a 1-10 scale. No pain it itated in the triage area. The of the treatment area five hours ceived pain medication one mately 20 hours after she of at 0830 hours on 5/1/07, a insultation was provided to abdominal pain for Patient O. I record for Patient O revealed in the treatment of the record eneral surgery consultation by a Physician Assistant (PA- locumentation to reveal that ency consultations by a PA-C consistent with the rules and dical staff bylaws of the electrical content of the regery for an exploratory			Corrective Actions — Patient O: The Chief Medical Officer notified Medical Director that physician as no longer perform medical screen examinations. (Attachment A) The ED Medical Director informed physician assistant, by e-mail, that no longer perform medical screen examinations. The ED Nurse Manager provided all ED RNs on the requirement to physicians of all patients waiting to that are experiencing pain which resident information must be documented information must be documented information must be documented in patient's medical record. A multidisciplinary team of ED phy ED nurses reviewed the current transfer process. As a result of that review process was re-designed to provide timely medical screening examinal process includes the following: (A) The triage nurse and register are co-located so to triaging process and the process can occur simult of A physician will be available triaging area to perform medical screening examination, and treatments (including management) will be ordered.	the ED sistants shalling I each they may ing education to notify o be seen equires licy. This in the risicians and lage that the risicians and lage that the registration hat the registration taneously, able to the immediate inations for ed as a level the medical the medical tests g pain	

PRINTED: 06/12/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 050578 06/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LAC/MARTIN LUTHER KING JR GEN HOSPITAL LOS ANGELES, CA 90059 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX . PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-COMPLÉTIONS DATE: REFERENCED TO THE APPROPRIATE DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) ---TAG TAG" Patients who are identified as a A 455 Continued From page 10 A 455 Level 1 and 2 at the time of triage will be brought back to the being seen to determine if an emergency emergency treatment area. At the condition existed. She returned to the ED at time of arrival, the ED charge nurse 1306 hours on 5/14/07 with a complaint of vaginal will notify the physician of the patient's arrival by placing the bleeding for three days. She had 8/10 pain when patient's pseudo name on the white triaged by the nurse at 1315. There was no board along with the patient's priority documented evidence the ED nurse evaluated number. The physician will how much the patient was bleeding. She was not acknowledge the patient by initialing the white board and will perform the taken to the treatment area until four hours later medical screening examination as at 1730 hours. No pain medication/intervention soon as possible. If a patient's was given. Her medical screening exam was condition is critical, the RN will conducted by a physician's assistant. She verbally notify the physician. The Interim Medical Director instructed all passed the products of conception while having Department Chairs to ensure that their an ultrasound done and was discharged by a physicians provide timely consultation for physician at 2235 hours after having had a patients in the Emergency Department miscarriage. Monitoring: Ten medical records will be reviewed daily to 8. Patient O came to the ED of the hospital on 4/ track the time from triage to medical screening 30/07 at approximately 1207 hours. When examination. In addition, these records will be triaged at 1250 hours she identified she had reviewed to determine whether consultations were provided timely. Data from these daily sharp pain of 10 on a 1-10 scale. No pain reviews will be presented to the ED intervention were initiated in the triage area. The Collaborative Practice Committee and the patient was taken to the treatment area five hours process will be re-evaluated as a result of this later at 1815 and received pain medication one review. Data will also be presented to the Performance Improvement Committee hour later. Approximately 20 hours after she monthly, which will evaluate it, develop presented to the ED, at 0830 hours on 5/1/07, a corrective actions as necessary, and report it general surgery consultation was provided to to the Executive Committee and as evaluate the acute abdominal pain for Patient O. appropriate to the Governing Body. Once the

The closed medical record for Patient O revealed

"Dr."at bedside. However, review of the record

had been provided by a Physician Assistant (PA-

C). There was no documentation to reveal that

provision of emergency consultations by a PA-C was approved and consistent with the rules and

hospital, and the credentialing process of a mid-

level practitioner. The patient was admitted to the

regulations, the medical staff bylaws of the

hospital and had surgery for an exploratory

laparotomy ventral hernia repair.

revealed that the general surgery consultation

o

Executive Committee determines that the

validate pain documentation and nursing responses to pain of patients in waiting area. Corrective actions will be initiated for all

deficiencies. Aggregated results of these

audits are presented to the Performance

convert to a monthly review.

Governing Body as necessary.

process is stable, the daily record review will

Tracer rounds are conducted once a week, On

these rounds, staff reviews medical records to

Improvement Committee, which will evaluate it and develop corrective actions as necessary

and report it to Executive Committee and the

PRINTED: 06/12/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 050578 06/07/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12021 S WILMINGTON AVE LAC/MARTIN LUTHER KING JR GEN HOSPITAL LOS ANGELES, CA 90059 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PREFIX -- (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) A 455 Continued From page 11 A 455 Corrective Action - Patient P: See cover letter. : IT 9. Patient P came to the emergency department on 4/30/07 at approximately 1000 hours for the evaluation of a known ectopic pregnancy. At 1800 hours an nursing interval note indicated that Corrective Action - Page Q: A multidisciplinary team of ED physicians and the emergency department was unable to admit ED nurses reviewed the current triage Patient P to the hospital "due to short staff". process. As a result of that review, the triaging There was no nursing or physician documentation process was re-designed to provide for a more to indicate intervention to evaluate the appropriate timely medical screening examination. This process includes the following: (Attachment O) provision of care for Patient P. The patient was The triage nurse and registration admitted to an in-patient bed at 2100 hours. clerk are co-located so that the triaging process and the registration 10. Patient Q came to the emergency process can occur simultaneously. A physician will be available to the department of the hospital at approximately 2040 triaging area to perform immediate hours on 4/30/07. Patient Q stated that he was medical screening examinations for seeing aliens and devils. He was dropped off by patients who are identified as a level his family. At triage the nurse documented the 3. Upon completion of the medical screening examination, based on patient had suicidal ideations with a plan to drink the patient's clinical presentation, bleach. The nurse triaged the patient as a tests and treatments (including pain category 3 (stable major illness) and left him in management) will be ordered and the lobby for over one hour before taking him carried out. Patients who are identified as a back to the treatment area. Patient Q was Level 1 and 2 at the time of triage evaluated by the emergency department will be brought back to the physician at 0500 hours on 5/1/07, a delay of emergency treatment area. At the almost 7 hours. No psychiatric treatment or time of arrival, the ED charge nurse will notify the physician of the consultation was provided. Approximately 6

patients.

hours later, at 1055 hours on 5/1/07, an

evaluation by a mental health professional was

requested. The mental health evaluation was not

completed until four hours later at 1500 hours: 17

hours after he presented to the ED. The mental

Patient Q was discharged home at 2100 hours without receiving treatment. The hospital thus failed to ensure that the provision of emergency services had been provided within timeframes consistent with acceptable safety for psychiatric

being suicidal at the time of the evaluation.

health professional determined the patient denied

patient's arrival by placing the

number. The physician will

patient's pseudo name on the white

board along with the patient's priority

acknowledge the patient by initialing

the white board and will perform the

medical screening examination as

soon as possible. If a patient's

condition is critical, the RN will verbally notify the physician.

		AND HUMAN SERVICES & MEDICAID SERVICES			•	FORM	APPROVED		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) I	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU		•	COMPLE	TED		
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LACAIAI	RTIN LUTHER KING J	D CEN HOSDITAL		1	2021 S WILMINGTON AVE				
LACMMAI	TIM EUTHEN NING O	A GEN HOSPITAL		l	LOS ANGELES, CA 90059				
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					Monitoring:				
A 455	on 4/30/07 at approve valuation of a know 1800 hours an nursi the emergency department P to the hos. There was no nursir to indicate interventi provision of care for admitted to an in-partment of the hours on 4/30/07. Provision of care for admitted to an in-partment of the hours on 4/30/07. Provision aliens and dehis family. At triage patient had suicidal bleach. The nurse category 3 (stable mathematical bleach. No consultation was prohours later, at 1055 evaluation by a men requested. The mer completed until four hours after he presental the professional of being suicidal at the Patient Q was dischaution treceiving trefailed to ensure that services had been p	o the emergency department kimately 1000 hours for the vin ectopic pregnancy. At ng interval note indicated that artment was unable to admit pital "due to short staff". In gor physician documentation on to evaluate the appropriate Patient P. The patient was tient bed at 2100 hours. to the emergency ospital at approximately 2040 ratient Q stated that he was evils. He was dropped off by the nurse documented the ideations with a plan to drink triaged the patient as a rajor illness) and left him in the hour before taking him at area. Patient Q was ergency department ours on 5/1/07, a delay of psychiatric treatment or ovided. Approximately 6 hours on 5/1/07, an tal health professional was not hours later at 1500 hours; 17 noted to the ED. The mental determined the patient denied time of the evaluation. arged home at 2100 hours atment. The hospital thus the provision of emergency rovided within timeframes	A	155		m triage to addition, etermine ed timely. De Practice re- Data will nos as cutive ne ve ve eess is			
	consistent with acce	ptable safety for psychiatric							

patients.

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STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BÜI		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
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on 5/30 or Urgent Ca Each patie Physician medical re been evaluurgent Ca supervision department ensure that practitione record for timed entry physician. approxima admitted the provided be reviewed, the rules and redefineating was no doe privileging competent examination.	ats H, I, J, 5/31/07 are area o ent was exacted, treated, treated, treated, treated, treated, the had been pation by the exact pation at a medy 1030 at a medy the PA-there was egulation is under the provens in the mine if an area of the provens in the mine if an area of the provens in the mine if an area of the provens in the mine if an area of the provens in the mine if an area of the provens in the mine if an area of the provens in the mine if an area of the provens in the mine if an area of the provens in the mine if an area of the provens in the prove	K, L, M and N were evaluated at triage and sent to the if the emergency department. Camined and treated by a part and treated by a part and discharged from the hospital prior to the time of toring by the emergency and The facility failed to upervision of a mid-level on provided. The medical entialled to demonstrate a mergency department terviewed on 5/31/07 at hours, the PA-C readily lical screening examination, C was unsupervised. When no documentation in the s, or medical staff by laws vileges for the PA-C. There ion present in the PA-C assess their qualifications and ide medical screening emergency department and/emergency medical	A	155	Corrective Action — Patient H,I,J,K,L, The Chief Medical Officer notified the Medical Director that physician asson longer perform medical screening examinations. (Attachment A) The ED Medical Director informed a physician's assistant, by e-mail, the notion longer perform medical screening examinations. Monitoring: Ten randomly selected medical recreviewed daily to ensure that the miscreening exam is documented by a attending physician. Data will be protented to the Executive Committee. Once the Executive Committee concludes the process is stable, the daily record reconvert to a monthly review. Position Responsible: ED Medical Director	he ED istants shall ig each at they may ig ords will be edical an esented to imittee and the at the	6/12/07 -